MASSACHUSETTS

Blue Choice®

Summary of Benefits

Town of Brookline

Your Care

Your Primary Care Physician.

When you join Blue Choice, you must choose a primary care physician (PCP) for you and each member of your family. There are several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the *HMO Blue Provider Directory*; or call our Physician Selection Service at **1-800-821-1388.** If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care–Wherever You Are* for emergency care services). If your PCP determines that you need to see a specialist, you'll most likely be referred to a specialist affiliated with your PCP's hospital or group practice. Your physician may also work with Blue Cross Blue Shield concerning the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review is detailed in your subscriber certificates.

Your Choice to Seek Care on Your Own.

Your health care plan also allows you to seek most care without a PCP referral, at a lower level of coverage. You must choose a health care provider in Massachusetts who is a Blue Cross Blue Shield-participating provider for covered non-emergency services. When you choose to seek care on your own, some responsibility is yours. If you require hospitalization, you, or someone on your behalf, needs to call us before you're admitted (or within 48 hours of an emergency or maternity admission) to ensure maximum benefits.

You may have additional out-of-pocket expenses when you seek care without a referral from your PCP. These expenses include the following:

- For most services, you must meet a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. You pay a deductible each calendar year (**$250** per member or **$500** for all family members covered under the same membership). Then, you pay **20 percent** (called co-insurance) of the remaining covered charges. When services are furnished by a provider that has a payment agreement with Blue Cross Blue Shield of Massachusetts or with a local Blue Cross and/or Blue Shield plan, these providers usually accept the total charge allowed as full payment for covered services. See your subscriber certificates (and riders, if any) for information about the allowed charge and how your deductible and co-insurance are calculated.
- A co-insurance maximum protects you. When the money you've paid for your 20 percent co-insurance equals **$1,000** for a member in a calendar year (**$2,000** for all family members covered under the same membership), then your benefits (or your family's benefits) are provided in full, up to any benefit maximums, for the rest of that calendar year. Your PCP/Plan-approved outpatient copayments do not count toward your co-insurance maximum. You must still pay your copayment when it applies. See your subscriber certificates (and riders, if any) for information about the allowed charge and how your deductible and co-insurance are calculated.
- When you seek care without a referral from your PCP, your health care plan provides up to **$2,000,000** in benefits in a lifetime for each member.

Emergency Care–Wherever You Are.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). There is a **$25** copayment for emergency room services, which is waived if your stay is for observation or you're admitted to the hospital. Any necessary follow-up care must be arranged by your PCP.

When Outside the Service Area.

If you're traveling outside the service area and you need urgent or emergency care, you may go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. And, any additional follow-up care must be arranged by your PCP.

Dependent Benefits.

This plan covers dependents to age 26, or for two calendar years after the dependent is no longer claimed on the subscriber's or spouse's federal tax return, whichever comes first. Additionally, this plan may cover unmarried full-time students or other unmarried dependents who do not otherwise qualify as eligible dependents. Please see your subscriber certificates (and riders, if any) for exact coverage details.

Your Medical Benefits

Your health care plan offers you both the cost-effectiveness of a health maintenance organization, and the flexibility of a traditional major medical indemnity plan. When you receive services that are PCP/Plan approved, you and your family enjoy generous benefits. In addition, you have the flexibility to self-refer and receive the benefits associated with a traditional indemnity plan with more out-of-pocket expense.

Covered Services	Your Cost For PCP/Plan-Approved Benefits	Your Cost For Self-Referred Major Medical Benefits (after your deductible)
Outpatient Care		
Emergency room visits	$25 per visit (waived for observation stay or if admitted)	20% co-insurance*
Well-child care	$10 per visit	20% co-insurance (through age 5**)
Routine exams (including one GYN exam per calendar year)	$10 per visit	Not covered
Routine hearing exams	$10 per visit	Not covered
Routine vision exams (one every 12 months)	$10 per visit	Not covered
Family planning services–office visits	$10 per visit	20% co-insurance
Office visits	$10 per visit	20% co-insurance
Chiropractor services	$10 per visit (up to 20 visits per calendar year for members age 16 or older)	20% co-insurance
Short-term rehabilitation therapy–physical and occupational	$10 per visit (up to 60 visits per calendar year***)	20% co-insurance (as many days as medically necessary)
Speech, hearing, and language disorder treatment–speech therapy	$10 per visit	20% co-insurance
Allergy injections only	Nothing	20% co-insurance
Diagnostic X-rays, lab tests, and other tests	Nothing	20% co-insurance
Home health care, including hospice services	Nothing	20% co-insurance
Oxygen and equipment for its administration	Nothing	20% co-insurance
Durable medical equipment and repairs–such as wheelchairs, crutches, hospital beds (up to $1,500 per calendar year†)	All charges beyond beyond the calendar-year benefit maximum	20% co-insurance and all charges beyond the calendar-year benefit maximum
Prosthetic devices	20% co-insurance	20% co-insurance
Surgery and related anesthesia • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit	 $10 per visit $150 per admission††	 20% co-insurance 20% co-insurance
Inpatient Care (including maternity care)		
General hospital care (as many days as medically necessary)	$250 per admission††	20% co-insurance
Chronic disease hospital, rehabilitation hospital, or skilled nursing facility care (up to 100 days per calendar year)	Nothing	Not covered
Prescription Drug Benefit		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for generic $20 for brand-name	
Through the mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$10 for generic $20 for brand-name	

* If this visit is for emergency care, you will have to pay only a $25 copayment.

** This service is provided according to an age-based schedule.

*** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or to diagnose and treat speech, hearing, and language disorders.

† No dollar limit applies when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.

†† Your copayment for an inpatient admission followed by outpatient day surgery or additional inpatient care (or for outpatient day surgery followed by inpatient care) within 30 days for the same or related illness will not be more than $500.

Your Medical Benefits (continued)

Covered Services	Your Cost For PCP/Plan-Approved Benefits	Your Cost For Self-Referred Major Medical Benefits (after your deductible)
Mental Health and Substance Abuse Treatment		
Biologically based conditions* Inpatient admissions in a general hospital or mental hospital	$250 per admission**	20% co-insurance
Outpatient visits	$10 per visit	20% co-insurance
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	$250 per admission**	20% co-insurance
Inpatient admissions in a mental hospital or substance abuse treatment facility	$250 per admission** (up to 60 days per calendar year)	20% co-insurance (up to 60 days per calendar year)
Outpatient visits	$10 per visit (up to 24 visits per calendar year)	20% co-insurance (up to 24 visits per calendar year)
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	$250 per admission**	20% co-insurance
Inpatient admissions in a substance abuse treatment facility	$250 per admission** (up to 30 days per calendar year)	20% co-insurance (up to 30 days per calendar year)
Outpatient visits	$10 per visit (up to 8 visits per calendar year†)	20% co-insurance (up to 8 visits per calendar year†)

* Treatment for rape-related mental or emotional disorders and treatment for children under age 19 are covered to the same extent as biologically based conditions.

** Your copayment for an inpatient admission followed by outpatient day surgery or additional inpatient care (or for outpatient day surgery followed by inpatient care) within 30 days for the same or related illness will not be more than $500.

† The value of these visits is at least $500 in each calendar year.

Healthy Blue Programs

At Blue Cross Blue Shield of Massachusetts we offer you Healthy Blue, a group of programs, discounts and savings, resources, and tools to help you get the most you can from your health care plan. Call us at **1-800-782-3675** to receive our *Healthy Blue* booklet, which outlines these special programs.

LIVING HEALTHY *Babies*®´	No charge
A Fitness Benefit toward membership at a health club (see your subscriber certificates for details)	$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual/family
Living Healthy®´ Vision–discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Discounts on safety helmets and home safety items	Discount varies
Living Healthy®´ Naturally–discounts on different types of complementary and alternative medicine services such as acupuncture, massage therapy, nutritional counseling, personal training, Pilates, tai chi, and yoga	Up to a 30% discount
Blue Care® Line to answer your health care questions 24 hours a day–call 1-888-247-BLUE (2583)	No charge
Visit www.AHealthyMe.com for an around-the-clock healthy approach to fitness, family, and fun	No charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com**.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificates and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificates and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificates and riders.

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